General Information

Wisconsin Medicaid reimburses only those services that are medically necessary, appropriate, and, to the extent that alternative services are available, the most cost-effective.

The Nurse Anesthetist and Anesthesiologist Assistant Services Handbook includes information for *certified registered nurse anesthetists (CRNAs)* and *anesthesiologist assistants (AAs)* about covered services, reimbursement methodology, and billing.

Anesthesiologists should refer to the Physician Services Handbook, Anesthesia section, which includes information about covered services, reimbursement methodology, and billing.

For further information, go to Wisconsin Medicaid's Web site, *www.dhfs.state.wi.us/medicaid/*, which contains publications that may be downloaded, including Wisconsin Medicaid and BadgerCare handbooks and *Updates*.

What are Medicaid-Covered Nurse Anesthetist and Anesthesiologist Assistant Services?

Services provided by CRNAs and AAs include those anesthesia services prescribed by a physician that are within the scope of practice permitted CRNAs and AAs by their professional standards of practice. Refer to Appendix 1 of this handbook for a list of procedure codes covered by Wisconsin Medicaid for CRNAs and AAs.

Wisconsin Medicaid reimburses only those services that are medically necessary, appropriate, and, to the extent that alternative services are available, the most cost-effective. (Refer to the Glossary for Wisconsin Medicaid's definition of medically necessary services.)

Refer to HFS 107.03, Wis. Admin. Code, and to HFS 107.06(5), Wis. Admin. Code, for services *not covered* by Wisconsin Medicaid.

Appendix 8 of this handbook is a partial list of noncovered services. Wisconsin Medicaid does not reimburse for anesthesia services provided with a noncovered service.

Provider Eligibility and Certification

Certified Registered Nurse Anesthetist

To become a Wisconsin Medicaid-certified provider, a CRNA must be licensed as a registered nurse pursuant to s. 441.06, Wis. Stats.

A CRNA must also meet one of the following requirements:

- Current certification by either the Council on Certification of Nurse Anesthetists or the Council on Recertification of Nurse Anesthetists.
- Graduation within the previous 18 months from a nurse anesthesia program that meets the standards of the Council of Accreditation of Nurse Anesthesia Educational Programs and awaiting initial CRNA certification.

Anesthesiologist Assistant

To become a Wisconsin Medicaid-certified provider, an AA must have successfully completed both of the following:

- A four-year bachelor degree.
- An accredited two-year program for anesthesiologist assistants, consisting of specialized academic and clinical training in anesthesia.

Provider Numbers

Wisconsin Medicaid issues providers, whether individuals, agencies, or institutions, an eight-

digit provider number to bill Wisconsin Medicaid for services provided to eligible Medicaid recipients. A provider number belongs solely to the person, agency, or institution to whom it is issued. It is illegal for providers to bill using a provider number belonging to another provider.

A provider keeps the same provider number if he or she relocates, changes specialties, or voluntarily withdraws from Medicaid and later chooses to be reinstated. Provider numbers are never reissued to other providers in the event of termination from Wisconsin Medicaid.

Wisconsin Medicaid must be notified in writing of all changes in provider status (e.g., change in location or of specialty). Providers may use the Wisconsin Medicaid Provider Change of Address or Status Form in the Provider Certification section of the All-Provider Handbook. The form is also available on the Medicaid Web site at *www.dhfs.state.wi.us/medicaid/*.

Wisconsin Medicaid issues two types of provider numbers. Each type of provider number has its designated uses and restrictions. The two types are:

- Billing/performing provider number.
- Group billing number.

Billing/Performing Provider Number (Issued to Nurse Anesthetists and Anesthesiologist Assistants)

Wisconsin Medicaid issues a billing/performing provider number to CRNAs and AAs that allows them to identify themselves on the HCFA 1500 claim form as either the biller of services (in Element 33 of the HCFA 1500 claim form) or as the performer of services (in Element 24K of the HCFA 1500). Reimbursement is made directly to the provider indicated in Element 33, or to that provider's designated payee.

Nurse anesthetists or anesthesiologist assistants who do not indicate themselves as the billing provider on a claim are required to indicate:

- In Element 24K – the CRNA or AA's individual provider number as the performing provider.
- In Element 33 – a Medicaid-certified anesthesiology group or physician clinic name and Wisconsin Medicaid provider number.

Wisconsin Medicaid denies CRNA and AA claims submitted with any other kind of group (e.g., a hospital) or individual (e.g., a physician) in Element 33.

Group Billing Number (Issued to Clinics and Groups)

A group billing number is primarily an accounting convenience. An anesthesiology group or physician clinic using a group billing number receives one reimbursement and one Remittance and Status (R/S) Report for covered services performed by all individual providers within the clinic or group.

Individual providers within a clinic or group must also be Medicaid certified because the performing provider's Medicaid provider number must be indicated in Element 24K of the HCFA 1500 claim form when a group billing number is indicated in Element 33. A claim billed with only a group billing number is denied reimbursement. Refer to the HCFA 1500 claim form completion instructions in Appendix 2 of this handbook for more information.

Recipient Eligibility

Wisconsin Medicaid providers should verify recipient eligibility and identify any limitations to the recipient's coverage *before* providing services.

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Refer to the All-Provider Handbook for detailed information on accessing the Eligibility Verification System (EVS) and eligibility for Wisconsin Medicaid. For telephone numbers regarding recipient eligibility, refer to the page

of Important Telephone Numbers at the beginning of this handbook.

Medicaid Managed Care Coverage

Wisconsin Medicaid HMOs are required to provide at least the same benefits for enrollees as those provided under fee-for-service arrangements. For recipients enrolled in a Medicaid managed care program, all conditions of reimbursement and prior authorization (PA) for CRNA and AA services are established by the contract between the managed care program and the provider. Wisconsin Medicaid denies reimbursement for services covered by the recipient's Medicaid managed care program.

In most cases, Wisconsin Medicaid is the payer of last resort for any Medicaid-covered service.

Additional information regarding Medicaid managed care program noncovered services, emergency services, and hospitalization is located in the *Wisconsin Medicaid Managed Care Guide.*

Coordination of Benefits

Health Insurance Coverage

In most cases, Wisconsin Medicaid is the payer of last resort for any Medicaid-covered service. If the recipient is covered under commercial health insurance, Wisconsin Medicaid reimburses that portion of Medicaid's allowable cost remaining after commercial health insurance sources have been exhausted.

In some cases, Wisconsin Medicaid is the primary payer and must be billed *first*. Payers secondary to Medicaid include governmental programs such as:

- Birth to 3.
- The Crime Victim Compensation Fund.
- General Assistance (GA).
- Title V of the Social Security Act, Maternal and Child Health Services.
- The Wisconsin Adult Cystic Fibrosis Program.
- The Wisconsin Chronic Renal Disease Program.
- The Wisconsin Hemophilia Home Care Program.

Refer to the Coordination of Benefits section of the All-Provider Handbook for more information on services requiring health insurance billing, exceptions, the Other Coverage Discrepancy Report, and payers secondary to Medicaid.

Medicare Coverage

Recipients covered under both Medicare and Wisconsin Medicaid are referred to as dual entitlees. Claims for Medicare-covered services provided to dual entitlees must be billed to Medicare prior to Wisconsin Medicaid.

Nurse anesthetists and anesthesiologist assistants not certified by Medicare may be retroactively certified by Medicare for the date a service was provided. Contact the appropriate Medicare fiscal intermediary for certification information.

Providers are required to accept assignment on Medicare claims for dual entitlees. The dual entitlee is not liable for Medicare's coinsurance or deductible.

Usually, *Medicare-allowed* claims (called crossover claims) are automatically forwarded by Medicare to Wisconsin Medicaid for processing. If Wisconsin Medicaid has the provider's Medicare provider number, it will reimburse for the coinsurance and deductible within certain limits. These limits are described in the Coordination of Benefits section of the All-Provider Handbook. Medicaid reimburses for the coinsurance and deductible on crossover claims even if the service is not a Medicaid-covered service.

If the service provided to a dual entitlee is covered by Medicare (in at least some situations), but *Medicare denied* the service on a correctly completed claim, submit a new claim for the denied service to Medicaid and

indicate the appropriate Medicare disclaimer code in Element 11 of the HCFA 1500 claim form. Refer to Appendix 2 (Element 11) of this handbook for a list of the Medicare disclaimer codes.

Qualified Medicare Beneficiary Only

Qualified Medicare Beneficiary Only (QMB Only) recipients are eligible *only* for Wisconsin Medicaid payment of the coinsurance and the deductible for Medicare-allowed services.

Wisconsin Medicaid does not reimburse claims for QMB Only recipients that Medicare does not allow. Nurse anesthetists and anesthesiologist assistants are required to accept assignment on Medicare claims for QMB Only recipients.

Medicaid Abortion Policy

Coverage Policy

Wisconsin Medicaid reimburses anesthesia services when they are provided with a *covered* abortion. In accordance with s. 20.927, Wis. Stats., Wisconsin Medicaid covers abortions when one of the following situations exists:

- The abortion is directly and medically necessary to save the life of the woman, provided that prior to the abortion the physician attests in a signed, written statement, based on his or her best clinical judgement, that the abortion meets this condition.
- In a case of sexual assault or incest, provided that prior to the abortion the physician attests in a signed, written statement, to his or her belief that sexual assault or incest has occurred, *and* provided that the crime has been reported to the law enforcement authorities.
- Due to a medical condition existing prior to the abortion, the physician determines that the abortion is directly and medically necessary to prevent grave, long-lasting physical health damage to the woman, provided that prior to the abortion, the physician attests in a signed, written statement, based on his or her best clinical judgement, that the abortion meets this condition.

Covered Services

When an abortion meets the state and federal requirements for Medicaid coverage, Wisconsin Medicaid covers office visits and all other medically necessary related services. Also, Wisconsin Medicaid covers treatment for complications arising from an abortion, regardless of whether the abortion itself was a covered service. The complications represent new conditions for which care is medically necessary and reimbursable.

Noncovered Abortions

Services incidental to a noncovered abortion are not covered by Wisconsin Medicaid. Such services include, but are not limited to, any of the following services when directly related to the performance of a noncovered abortion:

- Laboratory testing and interpretation.
- Anesthesia.
- Recovery room services.
- Transportation.
- Follow-up visits.

Services incidental to a noncovered abortion are not covered by Wisconsin Medicaid.

Services Performed by Providers of a Noncovered Abortion

When a Medicaid provider performs a noncovered abortion on a Medicaid recipient and also provides other services for that same recipient within either nine months prior to or six weeks after the noncovered abortion, the provider must comply with the following:

- All claims pertaining to the recipient for whom the abortion was performed and having dates of service within the time period above must be submitted on paper, not electronically.
- Each claim must have attached to it the following certification statement, signed and dated:

Hospitals are required to obtain PA from Wisconsin Medicaid for all major organ transplants, even if the recipient is enrolled in a Medicaid managed care program.

"No service billed to Wisconsin Medicaid on the attached claim form was directly related to the performance of a non-Medicaid-covered abortion procedure. I understand that this statement is a representation to a material fact made in a claim for payment under Wisconsin Medicaid within the meaning of s. 49.49, Wis. Stats., and HFS 106.06(17), Wis. Admin. Code. Accordingly, if this statement is false, I understand that I am subject to criminal prosecution for Medicaid fraud or termination as a Medicaid provider, or both."

Provider's Name
Provider's Medicaid Number
Provider's Signature and Date

Documentation Requirement for Abortion, Hysterectomy, and Sterilization Claims

Wisconsin Medicaid requires *physicians* to attach specific documentation to claims when billing for abortions, hysterectomies, or sterilization procedures. *Before* providing anesthesia services for one of these procedures, CRNAs and AAs are advised to verify with the physician's office that the physician has obtained the necessary documentation. If the required documentation is not attached to the physician's claim, the physician's claim and *all* other claims related to the surgery are denied reimbursement. This includes the CRNA or AA's claim.

Prior Authorization for Major Organ Transplants

Nurse anesthetists and anesthesiologist assistants are not required to obtain PA. However, hospitals are required to obtain PA from Wisconsin Medicaid for all major organ transplants, even if the recipient is enrolled in a Medicaid managed care program. If the hospital fails to obtain PA, all claims for the transplant, including anesthesia services, are denied reimbursement.

For a list of major organ transplant services requiring PA, refer to the Hospital Handbook or to the Medicine and Surgery section of the Physician Services Handbook, which is available on the Medicaid Web site at *www.dhfs.state.wi.us/medicaid/*.